DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System - Update for Fiscal Year Beginning October 1, 2013 (FY 2014)

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice updates the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs). These changes are applicable to IPF discharges occurring during the fiscal year (FY) beginning October 1, 2013 through September 30, 2014.

DATES: Effective Date: The updated IPF prospective payment rates are effective for discharges occurring on or after October 1, 2013 through September 30, 2014.

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SUPPLEMENTARY INFORMATION:

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To assist readers in referencing sections contained in this document, we are providing the following table of contents.

Acronyms

Because of the many terms to which we refer by acronym in this notice, we are listing the acronyms used and their corresponding meanings in alphabetical order below:

BBRA Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, (Pub. L. 106-113)

CBSA	Core-Based Statistical Area
CCR	Cost-to-charge ratio
CAH	Critical access hospital
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders Fourth Edition--Text Revision
DRGs	Diagnosis-related groups
FY	Federal fiscal year (October 1 through September 30)
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
IPFs	Inpatient psychiatric facilities
IRFs	Inpatient rehabilitation facilities
LTCHs	Long-term care hospitals
MedPAR	Medicare provider analysis and review file
RPL	Rehabilitation, Psychiatric, and Long-Term Care
RY	Rate Year (July 1 through June 30)
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, (Pub. L. 97-248)

I. Executive Summary

A. Purpose

This notice updates the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilitates for discharges occurring during the fiscal year (FY) beginning October 1, 2013 through September 30, 2014.

B. Summary of the Major Provisions

In this notice, we update the IPF PPS, as specified in 42 CFR 412.428. The updates include the following:

- The FY 2008-based Rehabilitation, Psychiatric, and Long Term Care (RPL) market basket update of 2.6 percent adjusted by a 0.1 percentage point reduction as required by section 1886(s)(2)(A)(ii) of the Social Security Act (the Act) and a 0.5 percentage point reduction for economy-wide productivity as required by 1886(s)(2)(A)(i) of the Act.
- The fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.
- The electroconvulsive therapy payment by a factor specified by CMS.
- The national urban and rural cost-to-charge ratio medians and ceilings.
- The cost of living adjustment factors for IPFs located in Alaska and Hawaii, if appropriate.
- Description of the ICD-9-CM and MS-DRG classification changes discussed in the annual update to the hospital inpatient PPS regulations.

- Use of the best available hospital wage index and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality.
- The MS-DRG listing and comorbidity categories to reflect the ICD-9-CM revisions effective October 1, 2013.
- Retaining the 17 percent adjustment for IPFs located in rural areas, the 1.31 adjustment factor for IPFs with a qualifying emergency department, the coefficient value of 0.5150 for the teaching adjustment to the Federal per diem rate, the MS-DRG adjustment factors and comorbidity adjustment factors currently being paid to IPFs for FY 2013.

C. Summary of Transfers

Provision Description	Total Transfers
FY 2014 IPF PPS payment rate update	The overall economic impact of this notice is an estimated $115 million in increased payments to IPFs during FY 2014.

II. Background

A. Annual Requirements for Updating the IPF PPS

In November 2004, we implemented the inpatient psychiatric facilities (IPF) prospective payment system (PPS) in a final rule that appeared in the November 15, 2004 **Federal Register** (69 FR 66922). In developing the IPF PPS, in order to ensure that the IPF PPS is able to account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and certain patient and facility characteristics to determine those characteristics associated with

statistically significant cost differences on a per diem basis. For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

In that final rule, we explained that we believe it is important to delay updating the adjustment factors derived from the regression analysis until we have IPF PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. Therefore, we indicated that we did not intend to update the regression analysis and recalculate the Federal per diem base rate and the patient-and facility-level adjustments until we complete that analysis. Until that analysis is complete, we stated our intention to publish a notice in the **Federal Register** each spring to update the IPF PPS (71 FR 27041). In the May 6, 2011 IPF PPS final rule (76 FR 26432), we changed the payment rate update period to a rate year (RY) that coincides with a fiscal year (FY) update. Therefore, update notices are now published in the **Federal Register** in the summer to be effective on October 1. For further discussion on changing the IPF PPS payment rate update period to a RY that coincides with a FY, see the IPF PPS final rule published in the **Federal Register** on May 6, 2011 (76 FR 26434 through 26435).

Updates to the IPF PPS, as specified in 42 CFR §412.428, include the following:

- A description of the methodology and data used to calculate the updated Federal per diem base payment amount.

- The rate of increase factor as described in §412.424(a)(2)(iii), which is based on the Excluded Hospital with Capital market basket under the update methodology of

section 1886(b)(3)(B)(ii) of the Act for each year (effective from the implementation period until June 30, 2006).

• For discharges occurring on or after July 1, 2006, the rate of increase factor for the Federal portion of the IPF's payment, which is based on the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket.

• The best available hospital wage index and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality.

• Updates to the fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.

• Description of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) coding and diagnosis-related groups (DRGs) classification changes discussed in the annual update to the hospital inpatient prospective payment system (IPPS) regulations.

• Update to the electroconvulsive therapy (ECT) payment by a factor specified by CMS.

• Update to the national urban and rural cost-to-charge ratio medians and ceilings.

• Update to the cost of living adjustment factors for IPFs located in Alaska and Hawaii, if appropriate.

Our most recent IPF PPS annual update occurred in the August 7, 2012 **Federal Register** notice (77 FR 47224) (hereinafter referred to as the August 2012 IPF PPS notice) that set forth updates to the IPF PPS payment rates for FY 2013. That notice

updated the IPF PPS per diem payment rates that were published in the May 2011 IPF PPS final rule in accordance with our established policies.

Since implementation of the IPF PPS, we have explained that we believe it is important to delay updating the adjustment factors derived from the regression analysis until we have IPF PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. Because we are now approximately 8 years into the system, we believe that we have enough data to begin that process. Therefore, we have begun the necessary analysis to make future refinements. While we do not propose to make refinements in this notice, as explained in section V.D.3 below, we expect that in future rulemaking, for FY 2015, we will be ready to propose potential refinements.

B. Overview of the Legislative Requirements of the IPF PPS

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113) required the establishment and implementation of an IPF PPS. Specifically, section 124 of the BBRA mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units including an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units.

Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) extended the IPF PPS to distinct part psychiatric units of critical access hospitals (CAHs).

Section 3401(f) of the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by section 10319(e) of that Act and by section 1105(d) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (hereafter referred to as "the Affordable Care Act") added subsection (s) to section 1886 of the Act.

Section 1886(s)(1) is titled "Reference to Establishment and Implementation of System" and it refers to section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, which relates to the establishment of the IPF PPS.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY) and each subsequent RY. For the RY beginning in 2013 (that is, FY 2014), the productivity adjustment is equal to 0.5 percentage point, which we are implementing in this notice. Section 1886(s)(2)(A)(ii) of the Act requires the application of an "other adjustment" that reduces any update to an IPF PPS base rate by percentages specified in section 1886(s)(3) of the Act for the RY beginning in 2010 through the RY beginning in 2019. For the RY beginning in 2013 (that is, FY 2014), section 1886(s)(3)(B) of the Act requires the reduction to be 0.1 percentage point. We are implementing that provision in this FY 2014 IPF PPS notice.

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in RY 2014. We proposed and finalized new requirements for quality reporting for IPFs in the "Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates" proposed rule (May 11, 2012) (77 FR

27870, 28105 through 28116) and final rule (August 31, 2012) (77 FR 53258, 53644 through 53360).

To implement and periodically update these provisions, we have published various proposed and final rules in the Federal Register. For more information regarding these rules, see the CMS website at http://www.cms.hhs.gov/InpatientPsychFacilPPS/ .

C. General Overview of the IPF PPS

The November 2004 IPF PPS final rule (69 FR 66922) established the IPF PPS, as authorized under section 124 of the BBRA and codified at subpart N of part 412 of the Medicare regulations. The November 2004 IPF PPS final rule set forth the per diem Federal rates for the implementation year (the 18-month period from January 1, 2005 through June 30, 2006), and it provided payment for the inpatient operating and capital costs to IPFs for covered psychiatric services they furnish (that is, routine, ancillary, and capital costs, but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IPF PPS). Covered psychiatric services include services for which benefits are provided under the fee-for-service Part A (Hospital Insurance Program) Medicare program.

The IPF PPS established the Federal per diem base rate for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002. The average per diem cost was updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget neutrality.

The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate described above and certain patient- and facility-level payment

adjustments that were found in the regression analysis to be associated with statistically significant per diem cost differences.

The patient-level adjustments include age, DRG assignment, comorbidities, and variable per diem adjustments to reflect higher per diem costs in the early days of an IPF stay. Facility-level adjustments include adjustments for the IPF's wage index, rural location, teaching status, a cost of living adjustment for IPFs located in Alaska and Hawaii, and presence of a qualifying emergency department (ED).

The IPF PPS provides additional payment policies for: outlier cases; stop-loss protection (which was applicable only during the IPF PPS transition period); interrupted stays; and a per treatment adjustment for patients who undergo ECT.

A complete discussion of the regression analysis appears in the November 2004 IPF PPS final rule (69 FR 66933 through 66936).

Section 124 of BBRA did not specify an annual update rate strategy for the IPF PPS and was broadly written to give the Secretary discretion in establishing an update methodology. Therefore, in the November 2004 IPF PPS final rule, we implemented the IPF PPS using the following update strategy:

- Calculate the final Federal per diem base rate to be budget neutral for the 18-month period of January 1, 2005 through June 30, 2006.
- Use a July 1 through June 30 annual update cycle.
- Allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

III. Transition Period for Implementation of the IPF PPS

In the November 2004 IPF PPS final rule, we provided for a 3-year transition

period. During this 3-year transition period, an IPF's total payment under the PPS was based on an increasing percentage of the Federal rate with a corresponding decreasing percentage of the IPF PPS payment that was based on reasonable cost concepts. However, effective for cost reporting periods beginning on or after January 1, 2008, IPF PPS payments were based on 100 percent of the Federal rate.

IV. Changing the IPF PPS Payment Rate Update Period from a Rate Year to a Fiscal Year

Prior to RY 2012, the IPF PPS was updated on a July 1st through June 30th annual update cycle. Effective with RY 2012, we switched the IPF PPS payment rate update from a rate year that begins on July 1st ending on June 30th to a period that coincides with a fiscal year. In order to transition from a RY to a FY, the IPF PPS RY 2012 covered a 15 month period from July 1st through September 30th. As proposed and finalized, after RY 2012, the rate update period for the IPF PPS payment rates and other policy changes begin on October 1 through September 30. Therefore, the update cycle for FY 2014 will be October 1, 2013 through September 30, 2014.

For further discussion of the 15-month market basket update for RY 2012 and changing the payment rate update period from a RY to a FY, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998) and the RY 2012 IPF PPS final rule (76 FR 26432).

V. Market Basket for the IPF PPS

A. Background

The input price index (that is, the market basket) that was used to develop the IPF PPS was the Excluded Hospital with Capital market basket. This market basket was

based on 1997 Medicare cost report data and included data for Medicare participating IPFs, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), cancer hospitals, and children's hospitals. Although "market basket" technically describes the mix of goods and services used in providing hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term "market basket" as used in this document refers to a hospital input price index.

Beginning with the May 2006 IPF PPS final rule (71 FR 27046 through 27054), IPF PPS payments were updated using a FY 2002-based market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs (hereafter referred to as the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket).

We excluded cancer and children's hospitals from the RPL market basket because these hospitals are not reimbursed through a PPS; rather, their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which are implemented in regulations at §413.40. Moreover, the FY 2002 cost structures for cancer and children's hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs. A complete discussion of the FY 2002-based RPL market basket appears in the May 2006 IPF PPS final rule (71 FR 27046 through 27054).

In the May 1, 2009 IPF PPS notice (74 FR 20362), we expressed our interest in exploring the possibility of creating a stand-alone IPF market basket that reflects the cost structures of only IPF providers. We noted that, of the available options, one would be to join the Medicare cost report data from freestanding IPF providers (presently

incorporated into the RPL market basket) with data from hospital-based IPF providers (not currently incorporated in any market basket cost weights). We indicated that an examination of the Medicare cost report data comparing freestanding and hospital-based IPFs revealed considerable differences between the two with respect to cost levels and cost structures. At that time, we were unable to fully understand the differences between these two types of IPF providers. As a result, we felt that further research was required; therefore we solicited public comment for additional information that might help us to better understand the reasons for the variations in costs and cost structures, as indicated by the cost report data, between freestanding and hospital-based IPFs (74 FR 20376).

We summarized the public comments received and our responses in the April 2010 IPF PPS notice (75 FR 23111 through 23113). Despite receiving comments from the public on this issue, we were unable to explain the observed differences in costs and cost structures between hospital-based and freestanding IPFs. Therefore, we did not believe it was appropriate, at the time, to incorporate data from hospital-based IPFs with those of freestanding IPFs to create a stand-alone IPF market basket.

In the RY 2012 IPF PPS proposed rule (76 FR 4998) and final rule (76 FR 26432), we proposed and finalized the use of a rebased and revised FY 2008-based RPL market basket to update IPF payments. In the RY 2012 IPF PPS proposed rule (76 FR 5001), we also welcomed public comment on the possibility of using a rehabilitation and psychiatric (RP) market basket to update IPF payments in the future. Comments received and our responses are summarized in the RY 2012 final rule (76 FR 26436).

We continue to explore the viability of creating separate market baskets from the current RPL market basket. In the FY 2013 IPPS/LTCH final rule (77 FR 53468 through

53476), we adopted the newly created FY 2009-based LTCH-specific market basket for use under the LTCH PPS beginning in FY 2013. We continue to investigate the use of an alternative market basket to update IPF PPS payments; however, for the FY 2014 IPF PPS update, we continue to use (as was done for the FY 2013 update) the percentage increase in the FY 2008-based RPL market basket to determine the IPF PPS market basket update. We still have concerns about cost differences between freestanding and hospital-based providers, which remain unexplained even when looking at more recent data. However, we remain interested in researching this topic further to determine if these data quality and representativeness concerns can be overcome, and have plans to conduct more analysis into the claims and cost data for IPFs. Any possible changes to the market basket used to update IPF payments would appear in a future rulemaking and be subject to public comment.

B. FY 2014 Market Basket Update

The FY 2014 update for the IPF PPS using the FY 2008-based RPL market basket and IHS Global Insight's second quarter 2013 forecast of the market basket components is 2.6 percent (prior to the application of any statutory adjustments). This includes increases in both the operating and the capital components for FY 2014 (that is, October 1, 2013 through September 30, 2014). IHS Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets.

As previously described in section I.B, section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 and each

subsequent RY. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the "MFP adjustment").

The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private non-farm business MFP. We refer readers to the BLS Web site at http://www.bls.gov/mfp to obtain the BLS historical published MFP data. The MFP adjustment for FY 2014 applicable to the IPF PPS is derived using a projection of MFP that is currently produced by IHS Global Insight, Inc. For a detailed description of the model currently used by IHS Global Insight, Inc. to project MFP, as well as a description of how the MFP adjustment is calculated, we refer readers to the FY 2012 IPPS/LTCH final rule (76 FR 51690 through 51692). Based on IHS Global Insight, Inc.'s 2013 second quarter forecast, the productivity adjustment for FY 2014 is 0.5 percentage point. Section 1886(s)(2)(A)(ii) of the Act also requires the application of an "other adjustment" that reduces any update to an IPF PPS base rate by percentages specified in section 1886(s)(3) of the Act for rate years beginning in 2010 through the RY beginning in 2019. For the RY beginning in 2013 (that is, FY 2014), the reduction is 0.1 percentage point. We are implementing the productivity adjustment and "other adjustment" in this FY 2014 IPF PPS notice.

C. Labor-Related Share

Due to variations in geographic wage levels and other labor-related costs, we believe that payment rates under the IPF PPS should continue to be adjusted by a

geographic wage index, which would apply to the labor-related portion of the Federal per diem base rate (hereafter referred to as the labor-related share).

The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. Based on our definition of the labor-related share, we include in the labor-related share the sum of the relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Business Support Services, All Other: Labor-related Services, and a portion of the Capital-Related cost weight.

Therefore, to determine the labor-related share for the IPF PPS for FY 2014, we used the FY 2008-based RPL market basket cost weights relative importance to determine the labor-related share for the IPF PPS. This estimate of the FY 2014 labor-related share is based on IHS Global Insight Inc.'s second quarter 2013 forecast, which is the same forecast used to derive the FY 2014 market basket update.

Table 1 below shows the FY 2014 relative importance labor-related share using the FY 2008-based RPL market basket along with the FY 2013 relative importance labor-related share.

Table 1—FY 2014 Relative Importance Labor-Related Share and the FY 2013 Relative Importance Labor-Related Share based on the FY 2008-Based RPL Market Basket

	FY 2013 Relative Importance Labor-Related Share[1]	FY 2014 Relative Importance Labor-Related Share[2]
Wages and Salaries	48.796	48.394

	FY 2013 Relative Importance Labor-Related Share[1]	FY 2014 Relative Importance Labor-Related Share[2]
Employee Benefits	13.021	12.963
Professional Fees: Labor-Related	2.070	2.065
Administrative and Business Support Services	0.417	0.415
All Other: Labor-Related Services	2.077	2.080
Subtotal	66.381	65.917
Labor-Related Portion of Capital Costs (46%)	3.600	3.577
Total Labor-Related Share	**69.981**	**69.494**

1. Published in the FY 2013 IPF PPS notice (77 FR 47228) and based on IHS Global Insight, Inc.'s second quarter 2012 forecast of the FY 2008-based RPL market basket.
2. Based on IHS Global Insight, Inc.'s second quarter 2013 forecast of the FY 2008-based RPL market basket.

The labor-related share for FY 2014 is the sum of the FY 2014 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2008) and FY 2014. The sum of the relative importance for FY 2014 for operating costs (Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Business Support Services, and All Other: Labor-related Services) is 65.917percent, as shown in Table 1 above. The portion of Capital-related cost that is influenced by the local labor market is estimated to be 46 percent. Since the relative importance for Capital-Related Costs is 7.776 percent of the FY 2008-based RPL market basket in FY 2014, we take 46 percent of 7.776 percent to determine the labor-related share of Capital-related cost for FY 2014. The result is 3.577 percent, which we add to 65.917 percent for the operating cost amount to determine the total labor-related share for FY 2014. Therefore, the labor-related share for the IPF PPS in FY 2014 is 69.494 percent. This labor-related share is determined using the same general methodology as employed in calculating all

previous IPF labor-related shares (see, for example, 69 FR 66952 through 66953). The wage index and the labor-related share are reflected in budget neutrality adjustments.

VI. Updates to the IPF PPS for FY Beginning October 1, 2013

The IPF PPS is based on a standardized Federal per diem base rate calculated from the IPF average per diem costs and adjusted for budget-neutrality in the implementation year. The Federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by the patient- and facility-level adjustments that are applicable to the IPF stay. A detailed explanation of how we calculated the average per diem cost appears in the November 2004 IPF PPS final rule (69 FR 66926).

A. Determining the Standardized Budget-Neutral Federal Per Diem Base Rate

Section 124(a)(1) of the BBRA required that we implement the IPF PPS in a budget neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget-neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97-248) methodology had the IPF PPS not been implemented.

Under the IPF PPS methodology, we calculated the final Federal per diem base rate to be budget neutral during the IPF PPS implementation period (that is, the 18-month period from January 1, 2005 through June 30, 2006) using a July 1 update cycle. We updated the average cost per day to the midpoint of the IPF PPS implementation period

(that is, October 1, 2005), and this amount was used in the payment model to establish the budget-neutrality adjustment.

A step-by-step description of the methodology used to estimate payments under the TEFRA payment system appears in the November 2004 IPF PPS final rule (69 FR 66926).

1. Standardization of the Federal Per Diem Base Rate and Electroconvulsive Therapy (ECT) Rate

In the November 2004 IPF PPS final rule, we describe how we standardized the IPF PPS Federal per diem base rate to account for the overall positive effects of the IPF PPS payment adjustment factors. To standardize the IPF PPS payments, we compared the IPF PPS payment amounts calculated from the FY 2002 Medicare Provider Analysis and Review (MedPAR) file to the projected TEFRA payments from the FY 2002 cost report file updated to the midpoint of the IPF PPS implementation period (that is, October 2005). The standardization factor was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. The standardization factor was calculated to be 0.8367.

As described in detail in the May 2006 IPF PPS final rule (71 FR 27045), in reviewing the methodology used to simulate the IPF PPS payments used for the November 2004 IPF PPS final rule, we discovered that due to a computer code error, total IPF PPS payments were underestimated by about 1.36 percent. Since the IPF PPS payment total should have been larger than the estimated figure, the standardization factor should have been smaller (0.8254 vs. 0.8367). In turn, the Federal per diem base rate and the ECT rate should have been reduced by 0.8254 instead of 0.8367.

To resolve this issue, in RY 2007, we amended the Federal per diem base rate and the ECT payment rate prospectively. Using the standardization factor of 0.8254, the average cost per day was effectively reduced by 17.46 percent (100 percent minus 82.54 percent = 17.46 percent).

2. Calculation of the Budget Neutrality Adjustment

To compute the budget neutrality adjustment for the IPF PPS, we separately identified each component of the adjustment, that is, the outlier adjustment, stop-loss adjustment, and behavioral offset.

A complete discussion of how we calculate each component of the budget neutrality adjustment appears in the November 2004 IPF PPS final rule (69 FR 66932 through 66933) and in the May 2006 IPF PPS final rule (71 FR 27044 through 27046).

a. Outlier Adjustment

Since the IPF PPS payment amount for each IPF includes applicable outlier amounts, we reduced the standardized Federal per diem base rate to account for aggregate IPF PPS payments estimated to be made as outlier payments. The outlier adjustment was calculated to be 2 percent. As a result, the standardized Federal per diem base rate was reduced by 2 percent to account for projected outlier payments.

b. Stop-Loss Provision Adjustment

As explained in the November 2004 IPF PPS final rule, we provided a stop-loss payment during the transition from cost-based reimbursement to the per diem payment system to ensure that an IPF's total PPS payments were no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. We reduced the standardized Federal per diem base rate by the percentage of aggregate IPF

PPS payments estimated to be made for stop-loss payments. As a result, the standardized Federal per diem base rate was reduced by 0.39 percent to account for stop-loss payments. Since the transition was completed in RY 2009, the stop-loss provision is no longer applicable, and for cost reporting periods beginning on or after January 1, 2008, IPFs were paid 100 percent PPS rates.

c. Behavioral Offset

As explained in the November 2004 IPF PPS final rule, implementation of the IPF PPS may result in certain changes in IPF practices, especially with respect to coding for comorbid medical conditions. As a result, Medicare may make higher payments than assumed in our calculations. Accounting for these effects through an adjustment is commonly known as a behavioral offset.

Based on accepted actuarial practices and consistent with the assumptions made in other PPSs, we assumed in determining the behavioral offset that IPFs would regain 15 percent of potential "losses" and augment payment increases by 5 percent. We applied this actuarial assumption, which is based on our historical experience with new payment systems, to the estimated "losses" and "gains" among the IPFs. The behavioral offset for the IPF PPS was calculated to be 2.66 percent. As a result, we reduced the standardized Federal per diem base rate by 2.66 percent to account for behavioral changes. As indicated in the November 2004 IPF PPS final rule, we do not plan to change adjustment factors or projections until we analyze IPF PPS data.

If we find that an adjustment is warranted, the percent difference may be applied prospectively to the established PPS rates to ensure the rates accurately reflect the payment level. In conducting this analysis, we will be interested in the extent to which

improved coding of patients' principal and other diagnoses, which may not reflect real increases in underlying resource demands, has occurred under the PPS.

B. Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Rate

As described in the November 2004 IPF PPS final rule (69 FR 66931), the average per diem cost was updated to the midpoint of the implementation year. This updated average per diem cost of $724.43 was reduced by--(1) 17.46 percent to account for standardization to projected TEFRA payments for the implementation period; (2) 2 percent to account for outlier payments; (3) 0.39 percent to account for stop-loss payments; and (4) 2.66 percent to account for the behavioral offset. The Federal per diem base rate in the implementation year was $575.95. The increase in the per diem base rate for RY 2009 included the 0.39 percent increase due to the removal of the stop-loss provision. We indicated in the November 2004 IPF PPS final rule (69 FR 66932) that we would remove this 0.39 percent reduction to the Federal per diem base rate after the transition. As discussed in section IV.D.2. of the May 2008 IPF PPS notice, we increased the Federal per diem base rate and the ECT base rate by 0.39 percent in RY 2009. Therefore for RY 2009 and beyond, the stop-loss provision has ended and is no longer a part of budget neutrality.

In accordance with section 1886(s)(2)(A)(ii) of the Act, which requires the application of an "other adjustment," described in section 1886(s)(3) of the Act (specifically, section 1886(s)(3)(B)) for RYs 2013 and 2014 that reduces the update to the IPF PPS base rate for the FY beginning in Calendar Year (CY) 2013, we are adjusting the IPF PPS update by a 0.1 percentage point reduction for FY 2014. In addition, in accordance with section 1886(s)(2)(A)(i) of the Act, which requires the application of the

productivity adjustment that reduces the update to the IPF PPS base rate for the FY beginning in CY 2013, we are adjusting the IPF PPS update by a 0.5 percentage point reduction for FY 2014.

For this notice, we are applying an annual update of 2.0 percent (that is the FY 2008-based RPL market basket increase for FY 2014 of 2.6 percent less the productivity adjustment of 0.5 percentage point less the 0.1 percentage point required under section1886(s)(3)(B) of the Act) , and the wage index budget neutrality factor of 1.0010 to the FY 2013 Federal per diem base rate of $698.51, yielding a Federal per diem base rate of $713.19 for FY 2014. Similarly, we are applying the 2.0 percent payment update, and the 1.0010 wage index budget neutrality factor to the FY 2013 ECT base rate, yielding an ECT base rate of $307.04 for FY 2014.

As noted above, section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in RY 2014. We finalized new requirements for quality reporting for IPFs in the "Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates" final rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for RY 2014 and each subsequent rate year, the Secretary shall reduce any annual update to a standard Federal rate for discharges occurring during the rate year by 2.0 percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, we are applying a 2.0 percentage point reduction to the federal per diem base rate and the ECT base rate as follows.

For IPFs that fail to submit quality reporting data under the IPFQR program, we are applying a 0 percent annual update (that is 2 percent reduced by 2 percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0010 to the FY 2013 Federal per diem base rate of $698.51, yielding a Federal per diem base rate of $699.21 for FY 2014.

Similarly, we are applying the 0 percent annual update and the 1.0010 wage index budget neutrality factor to the FY 2013 ECT base rate of $300.72, yielding an ECT base rate of $301.02 for FY 2014.

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 27485), we are adopting two new measures for the FY 2016 payment determination and subsequent years for the IPFQR Program. We are also finalizing a request for voluntary information whereby IPFs will be asked to provide information on the patient experience of care survey they use.

VII. Update of the IPF PPS Adjustment Factors

A. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the FY 2002 MedPAR data file, which contained 483,038 cases. For this notice, we used the same results of the regression analysis used to implement the November 2004 IPF PPS final rule. For a more detailed description of the data file used for the regression analysis, see the November 2004 IPF PPS final rule (69 FR 66935 through 66936). While we have since used more recent claims data to set the fixed dollar loss threshold amount, we used the same results of this regression analysis to update the IPF PPS for FY 2013 and for FY 2014. Now that we are approximately 8 years into the

IPF PPS, we believe that we have enough data to begin looking at the process of refining the IPF PPS as appropriate. We expect that in future rulemaking, we may propose potential refinements to the system.

As we stated previously, we do not plan to update the regression analysis until we are able to analyze IPF PPS claims and cost report data. However, we continue to monitor claims and payment data independently from cost report data to assess issues, to determine whether changes in case-mix or payment shifts have occurred among freestanding governmental, non-profit and private psychiatric hospitals, and psychiatric units of general hospitals, and CAHs and other issues of importance to IPFs.

B. Patient-Level Adjustments

In the August 2012 IPF PPS notice (77 FR 47230 through 47233) we announced payment adjustments for the following patient-level characteristics: Medicare Severity diagnosis related groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments.

1. Adjustment for MS–DRG Assignment

The IPF PPS includes payment adjustments for designated psychiatric DRGs assigned to the claim based on each patient's principal diagnosis. As we did in FY 2013 (77 FR 47231), for FY 2014, we will make a payment adjustment for psychiatric diagnoses that group to one of the 17 MS-IPF-DRGs listed in Table 2. The DRG adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis.

In accordance with §412.27(a), payment under the IPF PPS is conditioned on IPFs admitting "only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in Chapter Five ('Mental Disorders') of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)" or in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, (DSM–IV–TR). IPF claims with a principal diagnosis included in Chapter Five of the ICD–9–CM or the DSM–IV–TR are paid the Federal per diem base rate under the IPF PPS and all other applicable adjustments, including any applicable DRG adjustment. Psychiatric principal diagnoses that do not group to one of the 17 designated DRGs will still receive the Federal per diem base rate and all other applicable adjustments, but the payment will not include a DRG adjustment.

The Standards for Electronic Transaction final rule published in the **Federal Register** on August 17, 2000 (65 FR 50312), adopted ICD–9–CM as the designated code set for reporting diseases, injuries, impairments, other health related problems, their manifestations, and causes of injury, disease, impairment, or other health related problems. Therefore, we use ICD–9–CM as the designated code set for the IPF PPS.

We believe that it is important to maintain the same diagnostic coding and DRG classification for IPFs that are used under the IPPS for providing psychiatric care. Therefore, when the IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, we adopted the same diagnostic code set and DRG patient classification system (that is, the CMS DRGs) that were utilized at the time under the

hospital inpatient IPPS. Since the inception of the IPF PPS, the DRGs used as the patient classification system under the IPF PPS have corresponded exactly with the CMS DRGs applicable under the IPPS for acute care hospitals.

Every year, changes to the ICD–9–CM coding system are addressed in the IPPS proposed and final rules. The changes to the codes are effective October 1 of each year and must be used by acute care hospitals as well as other providers to report diagnostic and procedure information. The IPF PPS has always incorporated ICD–9–CM coding changes made in the annual IPPS update. We publish coding changes in a Transmittal/Change Request, similar to how coding changes are announced by the IPPS and LTCH PPS. Those ICD–9–CM coding changes are also published in the following IPF PPS FY update, in either the IPF PPS proposed and final rules, or in an IPF PPS update notice.

In the May 2008 IPF PPS notice (73 FR 25709), we discussed CMS' effort to better recognize resource use and the severity of illness among patients. CMS adopted the new MS-DRGs for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). A crosswalk, to reflect changes that were made to the DRGs under the IPF PPS to the new MS-DRGs, was provided (73 FR 25716). We believe by better accounting for patients' severity of illness in Medicare payment rates, the MS–DRGs encourage hospitals to improve their coding and documentation of patient diagnoses. The MS–DRGs, which are based on the IPPS MS-DRGs, represent a significant increase in the number of DRGs (from 538 to 745, an increase of 207). For a full description of the development and implementation of the MS–DRGs, see the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175).

All of the ICD–9–CM coding changes are reflected in the FY 2013 GROUPER, Version 31.0, effective for IPPS discharges occurring on or after October 1, 2013 through September 30, 2014. The GROUPER Version 31.0 software package assigns each case to an MS–DRG on the basis of the diagnosis and procedure codes and demographic information (that is, age, sex, and discharge status). The Medicare Code Editor (MCE) 31.0 uses the new ICD–9–CM codes to validate coding for IPPS discharges on or after October 1, 2013. The complete documentation of the GROUPER logic is available from 3M/Health Information System (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current MS-DRG Definitions Manual, version 30.0, is available on a CD for $225.00. Version 31.0 of this manual, which will include the final FY 2014 MS-DRG changes, will be available on CD for $225.00. These manuals may be obtained by writing to 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949-0303, or by obtaining an order form at the Web site: http://www.3MHIS.com. The IPF PPS has always used the same GROUPER and Code Editor as the IPPS. Therefore, the ICD–9–CM changes, which were reflected in the GROUPER Version 31.0 and MCE 31.0 on October 1, 2013, also became effective for the IPF PPS for discharges occurring on or after October 1, 2013.

The impact of the new MS–DRGs on the IPF PPS was negligible. Mapping to the MS–DRGs resulted in the current 17 MS–DRGs, instead of the original 15, for which the IPF PPS provides an adjustment. Although the code set is updated, the same associated adjustment factors apply now that have been in place since implementation of the IPF PPS, with one exception that is unrelated to the update to the codes. When DRGs 521

and 522 were consolidated into MS–DRG 895, we carried over the adjustment factor of 1.02 from DRG 521 to the newly consolidated MS–DRG. This was done to reflect the higher claims volume under DRG 521, with more than eight times the number of claims than billed under DRG 522. For a detailed description of the mapping changes from the original DRG adjustment categories to the current MS–DRG adjustment categories, we refer readers to the May 2008 IPF PPS notice (73 FR 25714).

The official version of the ICD–9–CM is available on CD-ROM from the U.S. Government Printing Office. The FY 2012 version can be ordered by contacting the Superintendent of Documents, U.S. Government Printing Office, Department 50, Washington, DC 20402–9329, telephone number (202)512–1800. Questions concerning the ICD–9–CM should be directed to Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, Mailstop C4–08–06, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. The website for the CD-ROM which contains the complete official version of the International Classification of Diseases, Ninth Revision, Clinical Modification is located at:

http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/CDROM.html

Further information concerning the official version of the ICD–9–CM can be found on the IPPS website at:

http://cms.hhs.gov/medicare/coding/icd9providerdiagnosticcodes/addendum.html

Transition to ICD-10-CM

We note that, in accordance with the requirements of the final rule published in the **Federal Register** on September 5, 2012 (77 FR 54664), we will be discontinuing our

current use of the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), effective with the compliance date for using the international Classification of Diseases, 10th revision, Clinical Modifications (ICD-10-CM) of October 1, 2014. The ICD-10-CM coding guidelines are available through the CMS website at:

www.cms.gov/Medicare/Coding/ICD10/downloads/pcs_2012_guidelines.pdf and http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10 or on the CDC's website at www.cdc.gov/nchs/data/icd10/10cmguidelines2012.pdf.

The MS–IPF-DRG adjustment factors (as shown in Table 2) will continue to be paid for discharges occurring in FY 2014. In FY 2015, the MS-IPF-DRG adjustment factors will be updated effective with the compliance date for using the ICD-10-CM of October 1, 2014.

TABLE 2—FY 2014 CURRENT MS–IPF-DRGS APPLICABLE FOR THE PRINCIPAL DIAGNOSIS ADJUSTMENT

MS-DRG	MS-DRG Descriptions	Adjustment Factor
056	Degenerative nervous system disorders w MCC.	1.05
057	Degenerative nervous system disorders w/o MCC.	1.05
080	Nontraumatic stupor & coma w MCC.	1.07
081	Nontraumatic stupor & coma w/o MCC.	1.07
876	O.R. procedure w principal diagnoses of mental illness.	1.22
880	Acute adjustment reaction & psychosocial dysfunction.	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive.	1.02
883	Disorders of personality & impulse control.	1.02
884	Organic disturbances & mental retardation.	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders.	0.99
887	Other mental disorder diagnoses.	0.92
894	Alcohol/drug abuse or dependence, left AMA.	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy.	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC.	0.88
897	Alcohol/drug abuse or dependence w/o	0.88

MS-DRG	MS-DRG Descriptions	Adjustment Factor
	rehabilitation therapy w/o MCC.	

2. Payment for Comorbid Conditions

The intent of the comorbidity adjustments is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain concurrent medical or psychiatric conditions that are expensive to treat. In the May 2011 IPF PPS final rule (76 FR 26451 through 26452), we explained that the IPF PPS includes 17 comorbidity categories and identified the new, revised, and deleted ICD–9–CM diagnosis codes that generate a comorbid condition payment adjustment under the IPF PPS for RY 2012 (76 FR 26451).

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, length of stay (LOS), or both treatment and LOS.

For each claim, an IPF may receive only one comorbidity adjustment within a comorbidity category, but it may receive an adjustment for more than one comorbidity category. Billing instructions require that IPFs must enter the full ICD–9–CM codes for up to 24 additional diagnoses if they co-exist at the time of admission or develop subsequently and impact the treatment provided.

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. The principal diagnoses were used to

establish the DRG adjustments and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM "code first" instructions apply. As we explained in the May 2011 IPF PPS final rule (76 FR 265451), the code first rule applies when a condition has both an underlying etiology and a manifestation due to the underlying etiology. For these conditions, ICD–9–CM has a coding convention that requires the underlying conditions to be sequenced first followed by the manifestation. Whenever a combination exists, there is a "use additional code" note at the etiology code and a code first note at the manifestation code.

As discussed in the MS–DRG section, it is our policy to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care.

For FY 2014, we are applying the 17 comorbidity categories for which we are providing an adjustment, their respective codes, and their respective adjustment factors in Table 3 below. In FY 2015, the diagnosis codes and adjustment factors for the comorbidity categories will be updated effective with the compliance date for using the ICD-10-CM of October 1, 2014.

TABLE 3—FY 2014 DIAGNOSIS CODES AND ADJUSTMENT FACTORS FOR COMORBIDITY CATEGORIES

Description of Comorbidity	Diagnoses Codes	Adjustment Factor
Developmental Disabilities	317, 3180, 3181, 3182, and 319.	**1.04**
Coagulation Factor Deficits	2860 through 2864.	**1.13**
Tracheostomy	51900 through 51909 and V440.	**1.06**
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585.	**1.11**
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859,586, V4511, V4512, V560, V561,	**1.11**

Description of Comorbidity	Diagnoses Codes	Adjustment Factor
	and V562.	
Oncology Treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25.	**1.07**
Uncontrolled Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093.	**1.05**
Severe Protein Calorie Malnutrition	260 through 262	**1.13**
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234.	**1.12**
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959.	**1.07**
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 29212, 2922, 30300, and 30400.	**1.03**
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219.	**1.11**
Gangrene	44024 and 7854.	**1.10**
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, V4611, V4612, V4613 and V4614.	**1.12**
Artificial Openings—Digestive and Urinary	56960 through 56969, 9975, and V441 through V446.	**1.08**
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029.	**1.09**
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897.	**1.11**

3. Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule (69 FR 66922), we analyzed the impact of age on per diem cost by examining the age variable (that is, the range of ages) for payment adjustments.

In general, we found that the cost per day increases with age. The older age groups are more costly than the under 45 age group, the differences in per diem cost increase for each successive age group, and the differences are statistically significant.

We do not plan to update the regression analysis until we are able to analyze IPF

PPS data. Therefore, for FY 2014, we are continuing to use the patient age adjustments currently in effect as shown in Table 4 below.

TABLE 4—Age Groupings and Adjustment Factors

Age	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

4. Variable Per Diem Adjustments

We explained in the November 2004 IPF PPS final rule (69 FR 66946) that the regression analysis indicated that per diem cost declines as the LOS increases. The variable per diem adjustments to the Federal per diem base rate account for ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF.

We used a regression analysis to estimate the average differences in per diem cost among stays of different lengths. As a result of this analysis, we established variable per diem adjustments that begin on day 1 and decline gradually until day 21 of a patient's stay. For day 22 and thereafter, the variable per diem adjustment remains the same each day for the remainder of the stay. However, the adjustment applied to day 1 depends upon whether the IPF has a qualifying ED. If an IPF has a qualifying ED, it receives a 1.31 adjustment factor for day 1 of each stay. If an IPF does not have a qualifying ED, it

receives a 1.19 adjustment factor for day 1 of the stay. The ED adjustment is explained in more detail in section VII.C.5 of this notice.

For FY 2014, we are continuing to use the variable per diem adjustment factors currently in effect as shown in Table 5 below. A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

Table 5—Variable Per Diem Adjustments

Day-Of-Stay	Adjustment Factor
Day 1- IPF Without a Qualifying ED	1.19
Day 1- IPF With a Qualifying ED	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
After Day 21	0.92

C. Facility-Level Adjustments

The IPF PPS includes facility-level adjustments for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage Index Adjustment

a. Background

As discussed in the May 2006 IPF PPS final rule (71 FR 27061) and in the May 2008 (73 FR 25719) and May 2009 IPF PPS notices (74 FR 20373), in order to provide an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Currently, an IPF's geographic wage index value is determined based on the actual location of the IPF in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) and (C).

b. Wage Index for FY 2014

Since the inception of the IPF PPS, we have used the pre-reclassified, pre-floor hospital wage index in developing a wage index to be applied to IPFs because there is not an IPF-specific wage index available and we believe that IPFs generally compete in the same labor market as acute care hospitals so the pre-reclassified, pre-floor inpatient acute care hospital wage index should be reflective of labor costs of IPFs. As discussed in the May 2006 IPF PPS final rule for FY 2007 (71 FR 27061 through 27067), under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, without taking into account geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS. For a complete description of these IPPS wage index adjustments, please see the CY 2013 IPPS/IRF PPS final rule (77 FR 53365 through 53374). We are continuing that practice for FY 2014.

We apply the wage index adjustment to the labor-related portion of the Federal rate, which is 69.494 percent. This percentage reflects the labor-related relative importance of the FY 2008-based RPL market basket for FY 2014 (see section V.C. of this notice).

Changes to the wage index are made in a budget neutral manner so that updates do not increase expenditures. For FY 2014, we are applying the most recent hospital wage index (that is, the FY 2013 pre-floor, pre-reclassified hospital wage index because this is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data (that is, data from hospital cost reports for the cost reporting period beginning during FY 2009), and applying an adjustment in accordance with our budget neutrality policy. This policy requires us to estimate the total amount of IPF PPS payments for FY 2013 using the labor-related share and the wage indices from FY 2013 divided by the total estimated IPF PPS payments for FY 2014 using the labor-related share and wage indices from FY 2014. The estimated payments are based on FY 2012 IPF claims, inflated to the appropriate FY. This quotient is the wage index budget neutrality factor, and it is applied in the update of the Federal per diem base rate for FY 2014 in addition to the market basket described in section VI.B. of this notice. The wage index budget neutrality factor for FY 2014 is 1.0010. The wage index applicable for FY 2014 appears in Table 1 and Table 2 in Addendum B of this notice.

In the May 2006 IPF PPS final rule for RY 2007 (71 FR 27061-27067), we adopted the changes discussed in the Office of Management and Budget (OMB) Bulletin No. 03-04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In adopting the OMB Core-Based Statistical Area (CBSA) geographic designations, we did not provide a separate transition for the CBSA-based

wage index since the IPF PPS was already in a transition period from TEFRA payments to PPS payments.

As was the case in FY 2013, for FY 2014, we will continue to use the CBSA geographic designations. The updated FY 2014 CBSA-based wage index values are presented in Tables 1 and 2 in Addendum B of this notice. A complete discussion of the CBSA labor market definitions appears in the May 2006 IPF PPS final rule (71 FR 27061 through 27067).

In keeping with established IPF PPS wage index policy, we will use the FY 2013 pre-floor, pre-reclassified hospital wage index (which is based on data collected from hospital cost reports submitted by hospitals for cost reporting periods beginning during FY 2009) to adjust IPF PPS payments beginning October 1, 2013.

c. OMB Bulletins

OMB publishes bulletins regarding CBSA changes, including changes to CBSA numbers and titles. In the May 2008 IPF PPS notice, we incorporated the CBSA nomenclature changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current IPF PPS wage index and stated that we expect to continue to do the same for all the OMB CBSA nomenclature changes in future IPF PPS rules and notices, as necessary (73 FR 25721). The OMB bulletins may be accessed online at http://www.whitehouse.gov/omb/bullentins/index.html.

In accordance with our established methodology, we have historically adopted any CBSA changes that are published in the OMB bulletin that corresponds with the hospital wage index used to determine the IPF PPS wage index. For FY 2014, we use the FY 2013 pre-floor, pre-reclassified hospital wage index to adjust the IPF PPS payments.

On February 28, 2013, OMB issued OMB Bulletin No. 13-01, which establishes revised delineations of statistical areas based on OMB standards published in the *Federal Register* on June 28, 2010 and 2010 Census Bureau data. Because the FY 2013 pre-floor, pre-reclassified hospital wage index was finalized prior to the issuance of this Bulletin, the FY 2013 pre-floor, pre-reclassified hospital wage index does not reflect OMB's new area delineations based on the 2010 Census and, thus, the FY 2014 IPF PPS wage index will not reflect the OMB changes. CMS intends to propose changes to the hospital wage index based on this OMB Bulletin in the FY 2015 IPPS/LTCH PPS proposed rule, as stated in the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27552 through 27553). Therefore, we anticipate that the OMB Bulletin changes will be reflected in the FY 2015 hospital wage index. Because we base the IPF PPS wage index on the hospital wage index from the prior year, we anticipate that the OMB Bulletin changes would be reflected in the FY 2016 IPPS PPS wage index.

2. Adjustment for Rural Location

In the November 2004 IPF PPS final rule, we provided a 17 percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. For FY 2014, we are applying a 17 percent payment adjustment for IPFs located in a rural area as defined at §412.64(b)(1)(ii)(C). As stated in the November 2004 IPF PPS final rule, we do not intend to update the adjustment factors derived from the regression analysis until we are able to analyze IPF PPS data. A complete discussion of the adjustment for rural locations appears in the November 2004

IPF PPS final rule (69 FR 66954).

3. Teaching Adjustment

In the November 2004 IPF PPS final rule, we implemented regulations at §412.424(d)(1)(iii) to establish a facility-level adjustment for IPFs that are, or are part of, teaching hospitals. The teaching adjustment accounts for the higher indirect operating costs experienced by hospitals that participate in graduate medical education (GME) programs. The payment adjustments are made based on the number of full-time equivalent (FTE) interns and residents training in the IPF and the IPF's average daily census.

Medicare makes direct GME payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals including those paid under a PPS, and those paid under the TEFRA rate-of-increase limits. These direct GME payments are made separately from payments for hospital operating costs and are not part of the IPF PPS. The direct GME payments do not address the estimated higher indirect operating costs teaching hospitals may face.

For teaching hospitals paid under the TEFRA rate-of-increase limits, Medicare does not make separate payments for indirect medical education costs because payments to these hospitals are based on the hospitals' reasonable costs which already include these higher indirect costs that may be associated with teaching programs.

The results of the regression analysis of FY 2002 IPF data established the basis for the payment adjustments included in the November 2004 IPF PPS final rule. The results showed that the indirect teaching cost variable is significant in explaining the higher costs of IPFs that have teaching programs. We calculated the teaching adjustment

based on the IPF's "teaching variable," which is one plus the ratio of the number of FTE residents training in the IPF (subject to limitations described below) to the IPF's average daily census (ADC).

We established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We imposed a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. The cap limits the number of FTE residents that teaching IPFs may count for the purpose of calculating the IPF PPS teaching adjustment, not the number of residents teaching institutions can hire or train. We calculated the number of FTE residents that trained in the IPF during a "base year" and used that FTE resident number as the cap. An IPF's FTE resident cap is ultimately determined based on the final settlement of the IPF's most recent cost report filed before November 15, 2004 (that is, the publication date of the IPF PPS final rule).

In the regression analysis, the logarithm of the teaching variable had a coefficient value of 0.5150. We converted this cost effect to a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value. We note that the coefficient value of 0.5150 was based on the regression analysis holding all other components of the payment system constant.

As with other adjustment factors derived through the regression analysis, we do not plan to rerun the regression analysis until we analyze IPF PPS data. Therefore, in this notice, for FY 2014, we are retaining the coefficient value of 0.5150 for the teaching adjustment to the Federal per diem base rate.

A complete discussion of how the teaching adjustment was calculated appears in the November 2004 IPF PPS final rule (69 FR 66954 through 66957) and the May 2008 IPF PPS notice (73 FR 25721).

a. FTE Intern and Resident Cap Adjustment

CMS had been asked to reconsider the original IPF teaching policy and permit a temporary increase in the FTE resident cap when an IPF increases the number of FTE residents it trains due to the acceptance of displaced residents (residents that are training in an IPF or a program before the IPF or program closed) when another IPF closes or closes its medical residency training program.

To help us assess how many IPFs had been, or were expected to be adversely affected by their inability to adjust their caps under §412.424(d)(1) and under these situations, we specifically requested public comment from IPFs in the May 1, 2009 IPF PPS notice (74 FR 20376 through 20377). A summary of the comments and our responses can be reviewed in the April 30, 2010 IPF PPS notice (75 FR 23106 through 23117). All of the commenters recommended that CMS modify the IPF PPS teaching adjustment policy, supporting a policy change that would permit the IPF PPS residency cap to be temporarily adjusted when that IPF trains displaced residents due to closure of an IPF or closure of an IPF's medical residency training program(s). The commenters recommended a temporary resident cap adjustment policy similar to the policies applied in similar contexts for acute care hospitals.

We agreed with the commenters that, when a hospital temporarily takes on residents because another hospital closes or discontinues its program, a temporary adjustment to the cap would be appropriate for a rotation that occurs in an IPF setting

(freestanding or units). In these situations, residents may have partially completed a medical residency training program at the hospital that has closed its training program and may be unable to complete their training at another hospital that is already training residents up to or in excess of its cap. We believe that it is appropriate to allow temporary adjustments to the FTE caps for an IPF that provides residency training to medical residents who have partially completed a residency training program at an IPF that closes or at an IPF that discontinues training residents in a residency training program(s) (also referred to as a "closed" program throughout this preamble). For this reason, we adopted the following temporary resident cap adjustment policies, similar to the temporary adjustments to the FTE cap used for acute care hospitals. We proposed and finalized that the cap adjustment would be temporary because it is resident specific and would only apply to the displaced resident(s) until the resident(s) completes training in that specialty. As under the IPPS policy for displaced residents, the IPF PPS temporary cap adjustment would apply only to residents that were still training at the IPF at the time the IPF closed or at the time the IPF ceased training residents in the residency training program(s). Residents who leave the IPF, for whatever reason, before the closure of the IPF hospital or medical residency training program would not be considered displaced residents for purposes of the IPF temporary cap adjustment policy. Similarly, as under the IPPS policy, medical students who match to a program at an IPF but the IPF or medical residency training program closes before the individual begins training at that IPF are also not considered displaced residents for purposes of the IPF temporary cap adjustments. For detailed information on these acute care hospital GME/IME payment policies, we refer the reader to the August 1, 2001 final rule

(66 FR 39899), July 30, 1999 final rule (64 FR 41522), and May 7, 1999 proposed rule (64 FR 24736). We note that although we adopted a policy under the IPF PPS that is consistent with the policy applicable under the IPPS, the actual caps under the two payment systems may not be commingled.

b. Temporary Adjustment to the FTE Cap to Reflect Residents Added Due to Hospital Closure

In the May 6, 2011 IPF PPS final rule (76 FR 26455), we indicated that we would allow an IPF to receive a temporary adjustment to the FTE cap to reflect residents added because of another IPF's closure. This adjustment is intended to account for medical residents who would have partially completed a medical residency training program at the hospital that has closed and may be unable to complete their training at another hospital because that hospital is already training residents up to or in excess of its cap. We made this change because IPFs have indicated a reluctance to accept additional residents from a closed IPF without a temporary adjustment to their caps. For purposes of this policy on IPF closure, we adopted the IPPS definition of "closure of a hospital" in 42 CFR §413.79(h) to mean the IPF terminates its Medicare provider agreement as specified in 42 CFR §489.52. Therefore, we added a new §412.424(d)(1)(iii)(F)(1) to allow a temporary adjustment to an IPF's FTE cap to reflect residents added because of an IPF's closure on or after July 1, 2011, to be effective for cost reporting periods beginning on or after July 1, 2011. Under this policy, we allow an adjustment to an IPF's FTE cap if the IPF meets the following criteria: (1) the IPF is training displaced residents from an IPF that closed on or after July 1, 2011; and (2) the IPF that is training the displaced residents from the closed IPF submits a request for a temporary adjustment

to its FTE cap to its Medicare contractor no later than 60 days after the hospital first begins training the displaced residents, and documents that the IPF is eligible for this temporary adjustment to its FTE cap by identifying the residents who have come from the closed IPF and have caused the IPF to exceed its cap, (or the IPF may already be over its cap), and specifies the length of time that the adjustment is needed. After the displaced residents leave the IPF's training program or complete their residency program, the IPF's cap would revert to its original level. This means that the temporary adjustment to the FTE cap would be available to the IPF only for the period of time necessary for the displaced residents to complete their training. Further, as under the IPPS policy, we also indicated that the total amount of temporary cap adjustment that can be distributed to all receiving hospitals cannot exceed the cap amount of the IPF that closed.

c. Temporary Adjustment to FTE Cap to Reflect Residents Affected by Residency Program Closure

In the May 6, 2011 final rule (76 FR 26455), we indicated that if an IPF that ceases training residents in a residency training program(s) agrees to temporarily reduce its FTE cap, we would allow another IPF to receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another IPF's residency training program. For purposes of this policy on closed residency programs, we adopted the IPPS definition of "closure of a hospital residency training program" to mean that the hospital ceases to offer training for residents in a particular approved medical residency training program as specified in §413.79(h). The methodology for adjusting the caps for the "receiving IPF" and the "IPF that closed its program" is described below.

i. Receiving IPF

We proposed and finalized that an IPF(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another IPF's residency training program for cost reporting periods beginning on or after July 1, 2011 if --

- The IPF is training additional residents from the residency training program of an IPF that closed its program on or after July 1, 2011.
- No later than 60 days after the IPF begins to train the residents, the IPF submits to its Medicare Contractor a request for a temporary adjustment to its FTE cap, documents that the IPF is eligible for this temporary adjustment by identifying the residents who have come from another IPF's closed program and have caused the IPF to exceed its cap,(or the IPF may already be in excess of its cap), specifies the length of time the adjustment is needed, and, submits to its Medicare contractor a copy of the FTE cap reduction statement by the IPF closing the residency training program.

In general, the temporary adjustment criteria established for closed medical residency training programs at IPFs is similar to the criteria established for closed IPFs. More than one IPF may be eligible to apply for the temporary adjustment because residents from one closed program may complete their training at one IPF, or at several IPFs. Also, an IPF would be eligible for the temporary adjustment only to the extent that the displaced residents would cause the IPF to exceed its FTE cap.

Finally, we proposed and finalized that IPFs meeting the proposed criteria would be eligible to receive temporary adjustments to their FTE caps for cost reporting periods beginning on or after July 1, 2011.

ii. IPF That Closed Its Program

We indicated that an IPF that agrees to train residents who have been displaced by

the closure of another IPF's resident teaching program, may receive a temporary FTE cap adjustment only if the IPF that closed a program:

- Temporarily reduces its FTE cap by the number of FTE residents, in each program year, training in the program at the time of the program's closure. The yearly reduction would be determined by deducting the number of those residents who would have been training in the program during the year of the closure, had the program not closed.

- No later than 60 days after the residents who were in the closed program begin training at another IPF, submits to its Medicare contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IPF training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were training at the time of the program's closure; identifies the IPFs to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

We proposed and finalized that the cap reduction for the IPF with the closed program would be based on the number of FTE residents in each program year who were in the program at the IPF at the time of the program's closure, and who begin training at another IPF.

A complete discussion on the temporary adjustment to the FTE cap to reflect residents added due to hospital closure and by residency program appears in the January 27, 2011 IPF PPS proposed rule (76 FR 5018 through 5020) and the May 6, 2011 IPF PPS final rule (76 FR 26453 through 26456).

4. Cost of Living Adjustment for IPFs Located in Alaska and Hawaii.

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county in which the IPF is located. As we explained in the November 2004 IPF PPS final rule, the FY 2002 data demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. Other Medicare PPSs (for example, the IPPS and LTCH PPS) have adopted a cost of living adjustment (COLA) to account for the cost differential of care furnished in Alaska and Hawaii.

We analyzed the effect of applying a COLA to payments for IPFs located in Alaska and Hawaii. The results of our analysis demonstrated that a COLA for IPFs located in Alaska and Hawaii would improve payment equity for these facilities. As a result of this analysis, we provided a COLA in the November 2004 IPF PPS final rule.

A COLA adjustment for IPFs located in Alaska and Hawaii is made by multiplying the nonlabor-related portion of the Federal per diem base rate by the applicable COLA factor based on the COLA area in which the IPF is located.

The COLA factors are published on the Office of Personnel Management (OPM) website (http://www.opm.gov/oca/cola/rates.asp).

We note that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR 591.207, the OPM established the following COLA areas:

- City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;
- City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

- City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;
- Rest of the State of Alaska.

As previously stated in the November 2004 IPF PPS final rule, we update the COLA factors according to updates established by the OPM. Sections 1911 through 1919 of the Nonforeign Area Retirement Equity Assurance Act, as contained in subtitle B of title XIX of the National Defense Authorization Act (NDAA) for Fiscal Year 2010 (Pub. L. 111-84, October 28, 2009), transitions the Alaska and Hawaii COLAs to locality pay. Under section 1914 of Pub. L. 111-84, locality pay is being phased in over a 3-year period beginning in January 2010, with COLA rates frozen as of the date of enactment, October 28, 2009, and then proportionately reduced to reflect the phase-in of locality pay.

When we published the proposed COLA adjustment factors in the January 2011 IPF proposed rule (76 FR 4998), we inadvertently selected the FY 2010 COLA rates. The FY 2010 COLA rates were reduced rates to account for the phase-in of locality pay. We did not intend to propose reduced COLA rates, and we do not believe it is appropriate to finalize the reduced COLAs that we showed in our January 2011 proposed rule. The 2009 COLA rates do not reflect the phase-in of locality pay. Therefore, we finalized the FY 2009 COLA rates, which are the same rates that were in effect for RY 2010 through RY 2012. We plan to address the COLA in the future refinement process in FY 2015. For FY 2014, IPFs located in Alaska and Hawaii will continue to receive the updated COLA factors based on the COLA area in which the IPF is located as shown in Table 6 below.

TABLE 6—COLA Factors for Alaska and Hawaii IPFs

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

(The above factors are based on data obtained from the U.S. Office of Personnel Management Web site at: http://www.opm.gov/oca/cola/rates.asp.)

5. Adjustment for IPFs with a Qualifying Emergency Department (ED)

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. We provide an adjustment to the Federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs incurred by a freestanding psychiatric hospital with a qualifying ED or a distinct part psychiatric unit of an acute hospital or a CAH for preadmission services otherwise payable under the Medicare Outpatient Prospective Payment System (OPPS) furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF (see §413.40(c)(2)) and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with one exception described below), regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying ED

receive an adjustment factor of 1.31 as the variable per diem adjustment for day 1 of each stay. If an IPF does not have a qualifying ED, it receives an adjustment factor of 1.19 as the variable per diem adjustment for day 1 of each patient stay.

The ED adjustment is made on every qualifying claim except as described below. As specified in §412.424(d)(1)(v)(B), the ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH. If we provided the ED adjustment in these cases, the hospital would be paid twice for the overhead costs of the ED, as stated in the November 2004 IPF PPS final rule (69 FR 66960).

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF.

For FY 2014, we are retaining the 1.31 adjustment factor for IPFs with qualifying EDs. A complete discussion of the steps involved in the calculation of the ED adjustment factor appears in the November 2004 IPF PPS final rule (69 FR 66959 through 66960) and the May 2006 IPF PPS final rule (71 FR 27070 through 27072).

D. Other Payment Adjustments and Policies

For FY 2014, the IPF PPS includes an outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients. In this section, we also explain the reason for ending the stop-loss provision that was applicable during the transition period.

1. Outlier Payments

In the November 2004 IPF PPS final rule, we implemented regulations at §412.424(d)(3)(i) to provide a per-case payment for IPF stays that are extraordinarily costly. Providing additional payments to IPFs for extremely costly cases strongly improves the accuracy of the IPF PPS in determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be incurred in treating patients who require more costly care and, therefore, reduce the incentives for IPFs to under-serve these patients.

We make outlier payments for discharges in which an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the Federal per diem payment amount for the case.

In instances when the case qualifies for an outlier payment, we pay 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to increase LOS in order to receive additional payments.

After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount of $11,600 through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target.

a. Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in §412.428(d), we are updating the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the regression analysis and payment simulations used to develop the IPF PPS, we established a 2 percent outlier policy which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the Federal per diem base rate for all other cases that are not outlier cases.

We believe it is necessary to update the fixed dollar loss threshold amount because an analysis of the latest available data (that is, FY 2012 IPF claims) and rate increases indicate that adjusting the fixed dollar loss amount is necessary in order to maintain an outlier percentage that equals 2 percent of total estimated IPF PPS payments.

In the May 2006 IPF PPS final rule (71 FR 27072), we describe the process by which we calculate the outlier fixed dollar loss threshold amount. We will continue to use this process for FY 2014. We begin by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine an outlier fixed dollar loss threshold amount that will result in estimated outlier payments being equal to 2 percent of total estimated payments under the simulation. Based on this process, using the FY 2012 claims data, we estimate that IPF outlier payments as a percentage of total estimated payments are approximately 1.7 percent in FY 2013. Thus, for this notice, we are updating the FY 2014 IPF outlier threshold amount to ensure that estimated FY 2014

outlier payments are approximately 2 percent of total estimated IPF payments. The outlier fixed dollar loss threshold amount of $11,600 for FY 2013 will be changed to $10,245 for FY 2014 to increase estimated outlier payments and thereby maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2014.

b. Update to IPF Cost-to-Charge Ratio Ceilings

As previously stated, under the IPF PPS, an outlier payment is made if an IPF's cost for a stay exceeds a fixed dollar loss threshold amount. In order to establish an IPF's cost for a particular case, we multiply the IPF's reported charges on the discharge bill by its overall cost-to-charge ratio (CCR). This approach to determining an IPF's cost is consistent with the approach used under the IPPS and other PPSs. In the June 2003 IPPS final rule (68 FR 34494), we implemented changes to the IPPS policy used to determine CCRs for acute care hospitals because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs in order to ensure that aberrant CCR data did not result in inappropriate outlier payments.

As we indicated in the November 2004 IPF PPS final rule, because we believe that the IPF outlier policy is susceptible to the same payment vulnerabilities as the IPPS, we adopted a method to ensure the statistical accuracy of CCRs under the IPF PPS (69 FR 66961). Specifically, we adopted the following procedure in the November 2004 IPF PPS final rule: We calculated two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and

rural IPFs using the most recent CCRs entered in the CY 2013 Provider Specific File.

To determine the rural and urban ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The upper threshold CCR for IPFs in FY 2014 is 1.8644 for rural IPFs, and 1.7066 for urban IPFs, based on CBSA-based geographic designations. If an IPF's CCR is above the applicable ceiling, the ratio is considered statistically inaccurate and we assign the appropriate national (either rural or urban) median CCR to the IPF.

We apply the national CCRs to the following situations:

++ New IPFs that have not yet submitted their first Medicare cost report.

++ IPFs whose overall CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).

++ Other IPFs for which the Medicare contractor obtains inaccurate or incomplete data with which to calculate a CCR.

For new IPFs, we are using these national CCRs until the facility's actual CCR can be computed using the first tentatively or final settled cost report.

We are not making any changes to the procedures for updating the CCR ceilings in FY 2014. However, we are updating the FY 2014 national median and ceiling CCRs for urban and rural IPFs based on the CCRs entered in the latest available IPF PPS Provider Specific File. Specifically, for FY 2014, and to be used in each of the three situations listed above, using the most recent CCRs entered in the CY 2013 Provider Specific File we estimate the national median CCR of 0.6220 for rural IPFs and the national median CCR of 0.4770 for urban IPFs. These calculations are based on the IPF's location (either urban or rural) using the CBSA-based geographic designations.

A complete discussion regarding the national median CCRs appears in the November 2004 IPF PPS final rule (69 FR 66961 through 66964).

2. Expiration of the Stop-Loss Provision

In the November 2004 IPF PPS final rule, we implemented a stop-loss policy that reduced financial risk to IPFs projected to experience substantial reductions in Medicare payments during the period of transition to the IPF PPS. This stop-loss policy guaranteed that each facility received total IPF PPS payments that were no less than 70 percent of its TEFRA payments had the IPF PPS not been implemented. This policy was applied to the IPF PPS portion of Medicare payments during the 3-year transition.

In the implementation year, the 70 percent of TEFRA payment stop-loss policy required a reduction in the standardized Federal per diem and ECT base rates of 0.39 percent in order to make the stop-loss payments budget neutral. As described in the May 2008 IPF PPS notice for RY 2009, we increased the Federal per diem base rate and ECT rate by 0.39 percent because these rates were reduced by 0.39 percent in the implementation year to ensure stop-loss payments were budget neutral.

The stop-loss provision ended during RY 2009 (that is for discharges occurring on or after July 1, 2008 through June 30, 2009). The stop-loss policy is no longer applicable under the IPF PPS.

3. Future Refinements

As we have indicated throughout this notice, we have delayed making refinements to the IPF PPS until we have adequate IPF PPS data on which to base those refinements. Specifically, we explained that we will delay updating the adjustment factors derived from the regression analysis until we have IPF PPS data that include as much information

as possible regarding the patient-level characteristics of the population that each IPF serves. Now that we are approximately 8 years into the system, we believe that we have enough data to begin that process. We have begun the necessary analysis to better understand IPF industry practices so that we may refine the IPF PPS as appropriate. Using more recent data, we plan to re-run the regression analyses and recalculate the Federal per diem base rate and the patient-and facility-level adjustments. While we are not making these refinements in this notice, we expect that in the rulemaking for FY 2015 we will be ready to present the results of our analysis.

For RY 2012, we published several areas of concern for future refinement and we invited comments on these issues in our RY 2012 proposed and final rules. For further discussion of these issues and to review public comments, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998) and final rule (76 FR 26432).

VIII. Secretary's Recommendations

Section 1886(e)(4)(A) of the Act requires the Secretary, taking into consideration the recommendations of MedPAC, to recommend update factors for inpatient hospital services (including IPFs) for each FY that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Section 1886(e)(5) of the Act requires the Secretary to publish the recommended and final update factors in the **Federal Register**.

In the past, the Secretary's recommendations and a discussion about the MedPAC recommendations for the IPF PPS were included in the IPPS proposed and final rules. The market basket update for the IPF PPS was also included in the IPPS proposed and final rules, as well as in the IPF PPS annual update.

Beginning FY 2013, however, we only publish the market basket update for the IPF PPS in the annual IPF PPS FY update and not in the IPPS proposed and final rules. Furthermore, for any years in which MedPAC makes recommendations for the IPF PPS, those recommendations will be noted and considered in the IPF PPS update.

MedPAC did not make any recommendations for the IPF PPS for FY 2014. For the update to the IPF PPS standard Federal rate for FY 2014, see section IV B. of this notice.

IX. Waiver of Notice and Comment

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect. We can waive this procedure, however, if we find good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of finding and its reasons in the notice.

We find it is unnecessary to undertake notice and comment rulemaking for this action because the updates in this notice do not reflect any substantive changes in policy, but merely reflect the application of previously established methodologies. Therefore, under 5 U.S.C 553(b)(3)(B), for good cause, we waive notice and comment procedures.

X. Collection of Information Requirements

This notice does not impose any new or revised information collection, recordkeeping, or third-party disclosure requirements. Consequently, it does not need additional Office of Management and Budget review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

XI. Regulatory Impact Analysis

A. Statement of Need

This notice will update the prospective payment rates for Medicare inpatient hospital services provided by IPF for discharges occurring during the FY beginning October 1, 2013 through September 30, 2014. We are applying the FY 2008-based RPL market basket increase of 2.6 percent, less the 0.1 percentage point required by sections 1886(s)(2)(A) (ii) and 1886(s)(3)(B) of the Act and less the productivity adjustment of 0.5 percentage point as required by 1886(s)(2)(A)(i) of the Act.

B. Overall Impact

We have examined the impact of this notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub.L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for a major notice with economically significant effects ($100 million or more in any 1 year). This notice is designated as economically "significant" under section 3(f)(1) of Executive Order 12866.

We estimate that the total impact of these changes for FY 2014 payments compared to FY 2013 payments will be a net increase of approximately $115 million. This reflects a $100 million increase from the update to the payment rates, as well as, a $15 million increase as a result of the update to the outlier threshold amount. Outlier payments are estimated to increase from 1.7 percent in FY 2013 to 2.0 percent in FY 2014.

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IPFs and most other providers and suppliers are small entities, either by nonprofit status or having revenues of $7 million to $34.5 million or less in any 1 year depending on industry classification (for details, refer to the SBA Small Business Size Standards found at http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf), or being nonprofit organizations that are not dominant in their markets."

Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IPFs or the proportion of IPFs' revenue that is derived from Medicare payments. Therefore, we assume that all IPFs are considered small entities. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA.

As shown in Table 7, we estimate that the overall revenue impact of this notice on all IPFs is to increase Medicare payments by approximately 2.3 percent. As a result, since the estimated impact of this notice is a net increase in revenue across all categories

of IPFs, the Secretary has determined that this notice will have a positive revenue impact on a substantial number of small entities. Medicare fiscal intermediaries, Medicare Administrative Contractors, and Carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this notice will not have an adverse impact on the rural hospitals based on the data of the 309 rural units and 73 rural hospitals in our database of 1,624 IPFs for which data were available. Therefore, the Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2014, that threshold is approximately $141 million. This notice will not impose spending costs on state, local, or tribal governments in the aggregate, or by the private sector, of $141 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise

has Federalism implications. As stated above, this notice would not have a substantial effect on state and local governments.

C. Anticipated Effects

We discuss the historical background of the IPF PPS and the impact of this notice on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

As discussed in the November 2004 and May 2006 IPF PPS final rules, we applied a budget neutrality factor to the Federal per diem and ECT base rates to ensure that total estimated payments under the IPF PPS in the implementation period would equal the amount that would have been paid if the IPF PPS had not been implemented. The budget neutrality factor includes the following components: outlier adjustment, stop-loss adjustment, and the behavioral offset. As discussed in the May 2008 IPF PPS notice (73 FR 25711), the stop-loss adjustment is no longer applicable under the IPF PPS.

In accordance with §412.424(c)(3)(ii), we indicated that we will evaluate the accuracy of the budget neutrality adjustment within the first 5 years after implementation of the payment system. We may make a one-time prospective adjustment to the Federal per diem and ECT base rates to account for differences between the historical data on cost-based TEFRA payments (the basis of the budget neutrality adjustment) and estimates of TEFRA payments based on actual data from the first year of the IPF PPS. As part of that process, we will reassess the accuracy of all of the factors impacting budget neutrality. In addition, as discussed in section VII.C.1 of this notice, we are using the wage index and labor-related share in a budget neutral manner by applying a wage index budget neutrality factor to the Federal per diem and ECT base rates. Therefore, the

budgetary impact to the Medicare program of this notice will be due to the market basket update for FY 2014 of 2.6 percent (see section V.B. of this notice) less the "other adjustment" of 0.1 percentage point according to sections 1886(s)(2)(A)(ii) and 1886 (s)(3)(B) of the Act, less the productivity adjustment of 0.5 percentage point required by section 1886 (s)(2)(A)(i)of the Act, and the update to the outlier fixed dollar loss threshold amount.

We estimate that the FY 2014 impact will be a net increase of $115 million in payments to IPF providers. This reflects an estimated $100 million increase from the update to the payment rates and a $15 million increase due to the update to the outlier threshold amount to increase outlier payments from approximately 1.7 percent in FY 2013 to 2.0 percent in FY 2014.

2. Impact on Providers

To understand the impact of the changes to the IPF PPS on providers, discussed in this notice, it is necessary to compare estimated payments under the IPF PPS rates and factors for FY 2014 versus those under FY 2013. The estimated payments for FY 2013 and FY 2014 will be 100 percent of the IPF PPS payment, since the transition period has ended and stop-loss payments are no longer paid. We determined the percent change of estimated FY 2014 IPF PPS payments to FY 2013 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the update to the outlier fixed dollar loss threshold amount, the labor-related share and wage index changes for the FY 2014 IPF PPS, and the market basket update for FY 2014, as adjusted by the "other adjustment" according to

sections 1886(s)(2)(A)(ii) and 1886(s)(3)(B) of the Act and the productivity adjustment according to section 1886(s)(2)(A)(i).

To illustrate the impacts of the FY 2014 changes in this notice, our analysis begins with a FY 2013 baseline simulation model based on FY 2012 IPF payments inflated to the midpoint of FY 2013 using IHS Global Insight Inc.'s most recent forecast of the market basket update (see section V.B. of this notice); the estimated outlier payments in FY 2013; the CBSA designations for IPFs based on OMB's MSA definitions after June 2003; the FY 2012 pre-floor, pre-reclassified hospital wage index; the FY 2013 labor-related share; and the FY 2013 percentage amount of the rural adjustment. During the simulation, the total estimated outlier payments are maintained at 2 percent of total IPF PPS payments.

Each of the following changes is added incrementally to this baseline model in order for us to isolate the effects of each change:

- The update to the outlier fixed dollar loss threshold amount.
- The FY 2013 pre-floor, pre-reclassified hospital wage index and FY 2014 labor-related share.
- The market basket update for FY 2014 of 2.6 percent less the “other adjustment” of 0.1 percentage point in accordance with sections 1886(s)(2)(A)(ii) and 1886(s)(3)(B) of the Act and less the productivity adjustment of 0.5 percentage point reduction in accordance with section 1886(s)(2)(A)(i) of the Act.

Our final comparison illustrates the percent change in payments from FY 2013 (that is, October 1, 2012 to September 30, 2013) to FY 2014 (that is, October 1, 2013 to September 30, 2014) including all the changes in this notice.

TABLE 7-IPF Impact Table for FY 2014

Projected Impacts (% Change In Columns 3-6)					
Facility by Type	**Number of Facilities**	**Outlier**	**CBSA Wage Index & Labor Share**	**Adjusted Market Basket Update[1]**	**Total Percent Change[2]**
(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
All Facilities	1,624	0.3	0.0	2.0	2.3
Total Urban	1,242	0.3	0.0	2.0	2.3
Total Rural	382	0.2	-0.1	2.0	2.1
Urban unit	834	0.4	0.0	2.0	2.5
Urban hospital	408	0.1	0.0	2.0	2.1
Rural unit	309	0.2	-0.1	2.0	2.2
Rural hospital	73	0.3	-0.2	2.0	2.0
By Type of Ownership:					
Freestanding IPFs					
Urban Psychiatric Hospitals					
Government	130	0.3	-0.1	2.0	2.2
Non-Profit	99	0.1	0.2	2.0	2.2
For-Profit	177	0.1	0.0	2.0	2.0
Rural Psychiatric Hospitals					
Government	36	0.5	-0.4	2.0	2.1
Non-Profit	13	0.1	0.0	2.0	2.1
For-Profit	23	0.1	-0.1	2.0	2.0
IPF Units					
Urban					
Government	131	0.8	0.1	2.0	2.9
Non-Profit	548	0.4	0.1	2.0	2.5
For-Profit	155	0.3	-0.2	2.0	2.0
Rural					
Government	80	0.2	-0.1	2.0	2.1
Non-Profit	163	0.3	0.0	2.0	2.2
For-Profit	66	0.3	-0.1	2.0	2.2
Unknown Ownership Type	3	0.0	0.2	2.0	2.2
By Teaching Status:					
Non-teaching	1,419	0.2	0.0	2.0	2.2
Less than 10% interns and residents to beds	109	0.5	0.0	2.0	2.5
10% to 30% interns and residents to beds	70	0.5	0.1	2.0	2.6
More than 30% interns and residents to beds	26	0.9	0.5	2.0	3.5

By Region:					
New England	111	0.4	0.5	2.0	3.0
Mid-Atlantic	256	0.4	-0.1	2.0	2.3
South Atlantic	233	0.2	-0.3	2.0	1.9
East North Central	258	0.3	0.1	2.0	2.4
East South Central	171	0.2	-0.7	2.0	1.6
West North Central	139	0.3	0.2	2.0	2.5
West South Central	234	0.2	-0.2	2.0	1.9
Mountain	99	0.3	-0.6	2.0	1.7
Pacific	123	0.5	0.9	2.0	3.5
By Bed Size:					
Psychiatric Hospitals					
Beds: 0-24	82	0.2	-0.3	2.0	1.9
Beds: 25-49	75	0.1	-0.1	2.0	1.9
Beds: 50-75	79	0.2	0.0	2.0	2.2
Beds: 76 +	245	0.1	0.0	2.0	2.1
Psychiatric Units					
Beds: 0-24	684	0.4	0.0	2.0	2.4
Beds: 25-49	306	0.4	0.2	2.0	2.5
Beds: 50-75	94	0.4	-0.1	2.0	2.2
Beds: 76 +	59	0.5	0.0	2.0	2.6

[1]This column reflects the payment update impact of the RPL market basket update for FY 2014 of 2.6 percent, a 0.1 percentage point reduction in accordance with sections 1886(s)(2)(A)(ii) and 1886(s)(3)(B) of the Act, and a 0.5 percentage point reduction for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.

[2]Percent changes in estimated payments from FY 2013 to FY 2014 include all of the changes presented in this notice. Note, the products of these impacts may be different from the percentage changes shown here due to rounding effects.

3. Results

Table 7 above displays the results of our analysis. The table groups IPFs into the categories listed below based on characteristics provided in the Provider of Services (POS) file, the IPF provider specific file, and cost report data from HCRIS:

- Facility Type
- Location
- Teaching Status Adjustment
- Census Region

- Size

The top row of the table shows the overall impact on the 1,624 IPFs included in this analysis.

In column 3, we present the effects of the update to the outlier fixed dollar loss threshold amount. We estimate that IPF outlier payments as a percentage of total IPF payments are 1.7 percent in FY 2013. Thus, we are adjusting the outlier threshold amount in this notice to set total estimated outlier payments equal to 2 percent of total payments in FY 2014. The estimated change in total IPF payments for FY 2014, therefore, includes an approximate 0.3 percent increase in payments because the outlier portion of total payments is expected to increase from approximately 1.7 percent to 2 percent.

The overall impact of this outlier adjustment update (as shown in column 3 of table 7), across all hospital groups, is to increase total estimated payments to IPFs by 0.3 percent. We do not estimate that any group of IPFs will experience a decrease in payments from this update. The largest increase in payments is estimated to reflect a 0.9 percent increase in payments for IPFs located in teaching hospitals with an intern and resident ADC ratio greater than 30 percent.

In column 4, we present the effects of the budget-neutral update to the labor-related share and the wage index adjustment under the CBSA geographic area definitions announced by OMB in June 2003. This is a comparison of the simulated FY 2014 payments under the FY 2013 hospital wage index under CBSA classification and associated labor-related share to the simulated FY 2013 payments under the FY 2012 hospital wage index under CBSA classifications and associated labor-related share. We

note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 4. However, there will be small distributional effects among different categories of IPFs. For example, we estimate the largest increase in payments to be a 0.9 percent increase for IPFs in the Pacific region and the largest decrease in payments to be a 0.7 percent decrease for IPFs in the East South Central region.

Column 5 shows the estimated effect of the update to the IPF PPS payment rates, which includes a 2.6 percent market basket update less the 0.1 percentage point in accordance with section 1886(s)(2)(A)(ii) and 1886(s)(3)(B)and less the productivity adjustment of 0.5 percentage point in accordance with section 1886(s)(2)(A)(i).

Column 6 compares our estimates of the total changes reflected in this notice for FY 2014, to our payments for FY 2013 (without these changes). This column reflects all FY 2014 changes relative to FY 2013. The average estimated increase for all IPFs is approximately 2.3 percent. This estimated net increase includes the effects of the 2.6 percent market basket update adjusted by the "other adjustment" of minus 0.1 percentage point, as required by sections 1886(s)(2)(A)(ii) and 1886(s)(3)(B)of the Act and the productivity adjustment of minus 0.5 percentage point, as required by section 1886(s)(2)(A)(i)of the Act. It also includes the overall estimated 0.3 percent increase in estimated IPF outlier payments from the update to the outlier fixed dollar loss threshold amount. Since we are making the updates to the IPF labor-related share and wage index in a budget-neutral manner, they will not affect total estimated IPF payments in the aggregate. However, they will affect the estimated distribution of payments among providers.

Overall, no IPFs are estimated to experience a net decrease in payments as a result of the updates in this notice. IPFs in urban areas will experience a 2.3 percent increase and IPFs in rural areas will experience a 2.1 percent increase. The largest payment increase is estimated at 3.5 percent for IPFs located in teaching hospitals with an intern and resident ADC ratio greater than 30 percent and IPFs in the Pacific region. This is due to the larger than average positive effect of the CBSA wage index and labor-related share updates and the higher volume of outlier payments for IPFs in these categories.

4. Effect on the Medicare Program

Based on actuarial projections resulting from our experience with other PPSs, we estimate that Medicare spending (total Medicare program payments) for IPF services over the next 5 years would be as shown in Table 8 below.

TABLE 8 Estimated Payments shown in current year dollars

Fiscal Year	Dollars in Millions
2014	5,420
2015	5,910
2016	6,500
2017	7,090
2018	7,570

These estimates are based on the current forecast of the increases in the RPL market basket, including an adjustment for productivity, for the FY beginning in 2014 and each subsequent RY, as required by section 1886(s)(2)(A)(i) of the Act, as follows:

- 2.1 percent for FY 2014.
- 2.3 percent for FY 2015.
- 2.6 percent for FY 2016.
- 2.6 percent for FY 2017.

- 2.5 percent for FY 2018.

The estimates in Table 8 also include the application of the "other adjustment," as required by sections 1886(s)(2)(A)(ii) and 1886 (s)(3)(B) of the Act, as follows:

- -0.3 percentage point for rate years beginning in 2014.
- -0.2 percentage point for rate years beginning in 2015.
- -0.2 percentage point for rate years beginning in 2016.
- -0.75 percentage point for rate years beginning in 2017.
- -0.75 percentage point for rate years beginning in 2018.

We estimate that there would be a change in fee-for-service Medicare beneficiary enrollment as follows:

- 2.2 percent in FY 2014.
- 4.1 percent in FY 2015.
- 5.0 percent in FY 2016.
- 5.5 percent in FY 2017.
- 4.4 percent in FY 2018.

5. Effect on Beneficiaries

Under the IPF PPS, IPFs will receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the FY 2014 IPF PPS but we continue to expect that paying prospectively for IPF services would enhance the efficiency of the Medicare program.

D. Alternatives Considered

The statute does not specify an update strategy for the IPF PPS and is broadly

written to give the Secretary discretion in establishing an update methodology. Therefore, we are updating the IPF PPS using the methodology published in the November 2004 IPF PPS final rule. Lastly, no alternative policy options were considered in this notice, since this notice does not initiate policy changes with regard to the IPF PPS. This notice simply provides an update to the rates for FY 2014.

E. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars_a004_a-4), in Table 9 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this notice. This table provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this notice and based on the data for 1,624 IPFs in our database. All expenditures are classified as Federal transfers to IPF Medicare providers.

Table 9—Accounting Statement: Classification of Estimated Expenditures, from the 2013 IPF PPS FY to the 2014 IPF PPS FY (in Millions)

Category	TRANSFERS
Annualized Monetized Transfers	$115
From Whom To Whom?	Federal Government To IPF Medicare Providers

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: May 29, 2013

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Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Approved: June 28, 2013

_____

Kathleen Sebelius,

Secretary.

BILLING CODE 4120-01-P

Addendum A—Rate and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	$713.19
Labor Share (0.69494)	$495.62
Non-Labor Share (0.30506)	$217.57

Per Diem Rate Applying the 2 Percentage Point Reduction

Federal Per Diem Base Rate	$699.21
Labor Share (0.69494)	$485.91
Non-Labor Share (0.30506)	$213.30

Fixed Dollar Loss Threshold Amount:

$10,245

Wage Index Budget Neutrality Factor:

1.0010

Facility Adjustments:

Rural Adjustment Factor	1.17
Teaching Adjustment Factor	0.5150
Wage Index	Pre-reclass Hospital Wage Index (FY2013)

Cost of Living Adjustments (COLAs):

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18

Area	Cost of Living Adjustment Factor
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Patient Adjustments:

ECT – Per Treatment	$307.04
ECT – Per Treatment Applying the 2 Percentage Point Reduction	$301.02

Variable Per Diem Adjustments:

	Adjustment Factor
Day 1 -- Facility Without a Qualifying Emergency Department	1.19
Day 1 -- Facility With a Qualifying Emergency Department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
After Day 21	0.92

Age Adjustments:

Age (in years)	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07

Age (in years)	Adjustment Factor
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

DRG Adjustments:

MS-DRG	MS-DRG Descriptions	Adjustment Factor
056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Comorbidity Adjustments:

Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Coagulation Factor Deficit	1.13
Tracheostomy	1.06
Eating and Conduct Disorders	1.12
Infectious Diseases	1.07
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.13
Drug/Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings – Digestive & Urinary	1.08
Severe Musculoskeletal & Connective Tissue Diseases	1.09

Comorbidity	Adjustment Factor
Poisoning	1.11

Addendum B – FY 2014 CBSA Wage Index Tables

In this addendum, we provide the wage index tables referred to in the preamble to this notice. The tables presented below are as follows:

Table1-FY 2014 Wage Index For Urban Areas Based on CBSA Labor Market Areas.

Table 2- FY 2014 Wage Index Based On CBSA Labor Market Areas For Rural Areas.

TABLE 1: FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8324
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.3532
10420	Akron, OH Portage County, OH Summit County, OH	0.8729
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8435

10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8647
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9542
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.7857
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9084
11020	Altoona, PA Blair County, PA	0.8898
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8506
11180	Ames, IA Story County, IA	0.9595
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2147
11300	Anderson, IN Madison County, IN	0.9547
11340	Anderson, SC Anderson County, SC	0.8929
11460	Ann Arbor, MI Washtenaw County, MI	1.0115
11500	Anniston-Oxford, AL Calhoun County, AL	0.7539

11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9268
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.8555
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9488
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9517
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1977

12220	Auburn-Opelika, AL Lee County, AL	0.7437
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9373
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9746
12540	Bakersfield, CA Kern County, CA	1.1611
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0147
12620	Bangor, ME Penobscot County, ME	1.0184
12700	Barnstable Town, MA Barnstable County, MA	1.2843
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8147
12980	Battle Creek, MI Calhoun County, MI	0.9912

13020	Bay City, MI Bay County, MI	0.9181
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8533
13380	Bellingham, WA Whatcom County, WA	1.1415
13460	Bend, OR Deschutes County, OR	1.1119
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0374
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8737
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8707
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8516
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7261
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8348
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8752
14060	Bloomington-Normal, IL McLean County, IL	0.9502

14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.8897
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2378
14500	Boulder, CO Boulder County, CO	1.0574
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8665
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0829
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3170
15180	Brownsville-Harlingen, TX Cameron County, TX	0.8612
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.8792
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9999
15500	Burlington, NC Alamance County, NC	0.8485
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9997
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1262
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0474

15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8834
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9153
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.8860
16180	Carson City, NV Carson City, NV	1.0559
16220	Casper, WY Natrona County, WY	1.0143
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8944
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9907
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8050
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.8820
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9215

16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9195
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8678
16940	Cheyenne, WY Laramie County, WY	0.9730
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0600
17020	Chico, CA Butte County, CA	1.1197
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	0.9508

17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8082
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7592
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9082
17660	Coeur d'Alene, ID Kootenai County, ID	0.9218
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9584
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9364
17860	Columbia, MO Boone County, MO Howard County, MO	0.8339
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8560
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8857
18020	Columbus, IN Bartholomew County, IN	0.9564

18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	0.9763
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8591
18700	Corvallis, OR Benton County, OR	1.0715
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL	0.8916
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8836
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9835
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8828
19180	Danville, IL Vermilion County, IL	0.9977
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8218
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.9145

19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9136
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7261
19500	Decatur, IL Macon County, IL	0.7993
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8716
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0469
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9616
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9361
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7398
20100	Dover, DE Kent County, DE	0.9893
20220	Dubuque, IA Dubuque County, IA	0.8662

20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0741
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9525
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9705
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.0806
20940	El Centro, CA Imperial County, CA	0.8602
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8294
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9097
21300	Elmira, NY Chemung County, NY	0.8205
21340	El Paso, TX El Paso County, TX	0.8426
21500	Erie, PA Erie County, PA	0.7823
21660	Eugene-Springfield, OR Lane County, OR	1.1454
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8401
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.0816

21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3663
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8108
22140	Farmington, NM San Juan County, NM	0.9323
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.8971
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9288
22380	Flagstaff, AZ Coconino County, AZ	1.2369
22420	Flint, MI Genesee County, MI	1.1257
22500	Florence, SC Darlington County, SC Florence County, SC	0.8087
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7679
22540	Fond du Lac, WI Fond du Lac County, WI	0.9158
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9833
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0363
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7848

23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9633
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9516
23420	Fresno, CA Fresno County, CA	1.1593
23460	Gadsden, AL Etowah County, AL	0.7697
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9631
23580	Gainesville, GA Hall County, GA	0.9327
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9259
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8340
24140	Goldsboro, NC Wayne County, NC	0.8560
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7250
24300	Grand Junction, CO Mesa County, CO	0.9415
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9125
24500	Great Falls, MT Cascade County, MT	0.7927

24540	Greeley, CO Weld County, CO	0.9593
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9793
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.8638
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9694
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9737
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3696
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8544
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9422
25260	Hanford-Corcoran, CA Kings County, CA	1.0992
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9525
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9087
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.0869

25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.8035
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8677
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.8843
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8024
26180	Honolulu, HI Honolulu County, HI	1.2156
26300	Hot Springs, AR Garland County, AR	0.8944
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7928
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	0.9933
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.8635
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.8667

26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9114
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	0.9870
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0120
27060	Ithaca, NY Tompkins County, NY	0.9249
27100	Jackson, MI Jackson County, MI	0.8511
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8177
27180	Jackson, TN Chester County, TN Madison County, TN	0.7672
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8883
27340	Jacksonville, NC Onslow County, NC	0.7957
27500	Janesville, WI Rock County, WI	0.9458

27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8263
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7359
27780	Johnstown, PA Cambria County, PA	0.8116
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8084
27900	Joplin, MO Jasper County, MO Newton County, MO	0.7828
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	0.9834
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0127
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9614
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9708

28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9102
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7325
28740	Kingston, NY Ulster County, NY	0.8953
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7575
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.8756
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0070
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9316
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8565
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7813
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0558
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9760
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8262

29540	Lancaster, PA Lancaster County, PA	0.9452
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0065
29700	Laredo, TX Webb County, TX	0.7486
29740	Las Cruces, NM Dona Ana County, NM	0.9044
29820	Las Vegas-Paradise, NV Clark County, NV	1.2076
29940	Lawrence, KS Douglas County, KS	0.8676
30020	Lawton, OK Comanche County, OK	0.8351
30140	Lebanon, PA Lebanon County, PA	0.7994
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9326
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9178
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9023
30620	Lima, OH Allen County, OH	0.9226
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9726

30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8595
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8456
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8550
31020	Longview, WA Cowlitz County, WA	1.0081
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2293
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.8862
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8870
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8615

31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.8584
31460	Madera-Chowchilla, CA Madera County, CA	0.8050
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1264
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0042
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.7839
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9413
31900	Mansfield, OH Richland County, OH	0.8993
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3586
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8603
32780	Medford, OR Jackson County, OR	1.0400
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9049
32900	Merced, CA Merced County, CA	1.2996

33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0130
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9694
33260	Midland, TX Midland County, TX	1.0640
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	0.9931
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1336
33540	Missoula, MT Missoula County, MT	0.9001
33660	Mobile, AL Mobile County, AL	0.7467
33700	Modesto, CA Stanislaus County, CA	1.2841
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7717
33780	Monroe, MI Monroe County, MI	0.8472
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.7858

34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8284
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.6768
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0340
34620	Muncie, IN Delaware County, IN	0.8734
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.1007
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8717
34900	Napa, CA Napa County, CA	1.6045
34940	Naples-Marco Island, FL Collier County, FL	0.9265
34980	Nashville-Davidson—Murfreesboro-Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	0.9061
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2698

35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1223
35300	New Haven-Milford, CT New Haven County, CT	1.2061
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.8932
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.2914
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8237
35840	North Port-Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9375
35980	Norwich-New London, CT New London County, CT	1.1376
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6654
36100	Ocala, FL Marion County, FL	0.8455

36140	Ocean City, NJ Cape May County, NJ	1.0307
36220	Odessa, TX Ector County, TX	0.9741
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9031
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8810
36500	Olympia, WA Thurston County, WA	1.1397
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	1.0037
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9082
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9433
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8117
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.3079
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.8838

37380	Palm Coast, FL Flagler County, FL	0.9880
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.7976
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7487
37700	Pascagoula, MS George County, MS Jackson County, MS	0.7662
37764	Peabody, MA Essex County, MA	1.0551
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.7819
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.8882
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0806
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0477
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7847

38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8585
38340	Pittsfield, MA Berkshire County, MA	1.0721
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9555
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4314
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9975
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1673
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9577
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1325
39140	Prescott, AZ Yavapai County, AZ	1.2009

39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0699
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9133
39380	Pueblo, CO Pueblo County, CO	0.8518
39460	Punta Gorda, FL Charlotte County, FL	0.8590
39540	Racine, WI Racine County, WI	0.9158
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9488
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.9823
39740	Reading, PA Berks County, PA	0.9072
39820	Redding, CA Shasta County, CA	1.4555
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0328

40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9695
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1396
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9088
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.0708
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8704
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9935

40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0234
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.8898
40660	Rome, GA Floyd County, GA	0.8844
40900	Sacramento-Arden-Arcade-Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4752
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8820
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1010
41100	St. George, UT Washington County, UT	0.8870
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	0.9856
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9420

41420	Salem, OR Marion County, OR Polk County, OR	1.1069
41500	Salinas, CA Monterey County, CA	1.6074
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9260
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9063
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8221
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.8936
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1922
41780	Sandusky, OH Erie County, OH	0.8347
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6327
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4804
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.7396

41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.4318
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3081

42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2038
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2670
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.8062
42140	Santa Fe, NM Santa Fe County, NM	1.0400
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6440
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.8968
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8260
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1771
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.8850
43100	Sheboygan, WI Sheboygan County, WI	0.9515
43300	Sherman-Denison, TX Grayson County, TX	0.8544
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8412
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9010
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.8338

43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9531
43900	Spartanburg, SC Spartanburg County, SC	0.9186
44060	Spokane, WA Spokane County, WA	1.0824
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9179
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0377
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8581
44220	Springfield, OH Clark County, OH	0.9236
44300	State College, PA Centre County, PA	0.9510
44600	Steubenville-Weirton, OH-WV Jefferson County, OH Brooke County, WV Hancock County, WV	0.7640
44700	Stockton, CA San Joaquin County, CA	1.3356
44940	Sumter, SC Sumter County, SC	0.7454
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9829
45104	Tacoma, WA Pierce County, WA	1.1741

45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8521
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9032
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9113
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.7967
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9034
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8969
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0360
46060	Tucson, AZ Pima County, AZ	0.9065
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8139

46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8533
46340	Tyler, TX Smith County, TX	0.8361
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8653
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.7918
46700	Vallejo-Fairfield, CA Solano County, CA	1.5844
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8992
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0596
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.9208
47300	Visalia-Porterville, CA Tulare County, CA	1.0349

47380	Waco, TX McLennan County, TX	0.8458
47580	Warner Robins, GA Houston County, GA	0.8197
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9543
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.0659
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8422
48140	Wausau, WI Marathon County, WI	0.8921
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	1.0037
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9661

48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6863
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8681
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9048
48700	Williamsport, PA Lycoming County, PA	0.8230
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0687
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9155
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9249
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8660
49340	Worcester, MA Worcester County, MA	1.1205
49420	Yakima, WA Yakima County, WA	1.0097
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.4059

49620	York-Hanover, PA York County, PA	0.9557
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8283
49700	Yuba City, CA[1] Sutter County, CA Yuba County, CA	1.2004
49740	Yuma, AZ Yuma County, AZ	0.9517

[1] At this time, there are no hospitals located in this urban area on which to base a wage index.

TABLE 2: FY 2014 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

State Code	Nonurban Area	Wage Index
1	Alabama	0.7121
2	Alaska	1.2807
3	Arizona	0.9182
4	Arkansas	0.7350
5	California	1.2567
6	Colorado	1.0208
7	Connecticut	1.1128
8	Delaware	1.0171
10	Florida	0.8062
11	Georgia	0.7421
12	Hawaii	1.0728
13	Idaho	0.7583
14	Illinois	0.8438
15	Indiana	0.8472
16	Iowa	0.8351
17	Kansas	0.7997
18	Kentucky	0.7877
19	Louisiana	0.7718

State Code	Nonurban Area	Wage Index
20	Maine	0.8300
21	Maryland	0.8797
22	Massachusetts	1.3540
23	Michigan	0.8387
24	Minnesota	0.9053
25	Mississippi	0.7537
26	Missouri	0.7622
27	Montana	0.8600
28	Nebraska	0.8733
29	Nevada	0.9739
30	New Hampshire	1.0372
31	New Jersey[1]	-----
32	New Mexico	0.8879
33	New York	0.8199
34	North Carolina	0.8271
35	North Dakota	0.6891
36	Ohio	0.8470
37	Oklahoma	0.7783
38	Oregon	0.9500
39	Pennsylvania	0.8380
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8338
43	South Dakota	0.8124
44	Tennessee	0.7559
45	Texas	0.7978
46	Utah	0.8516
47	Vermont	0.9725
48	Virgin Islands	0.7185
49	Virginia	0.7728
50	Washington	1.0092
51	West Virginia	0.7333
52	Wisconsin	0.9142

State Code	Nonurban Area	Wage Index
53	Wyoming	0.9238
65	Guam	0.9611

[1] All counties within the State are classified as urban, with the exception of Puerto Rico. Puerto Rico has areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2013. The Puerto Rico wage index is the same as FY 2012.

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